

ADULT HISTORY FORM

*Please complete this form and return it prior to your scheduled neuropsychological assessment appointment.
Thank you.*

Name: _____ **Date of Birth:** _____

Who referred you for the current evaluation? _____

Have you ever had a neuropsychological evaluation in the past? (Yes / No)

(if yes, when? _____ Name of neuropsychologist _____)

Please bring along a copy of the report from this evaluation, if you have it

What is your understanding of why they referred you for this current evaluation?

What are the questions that you would like the current evaluation to address?

1. _____

2. _____

3. _____

If you have any problems with your thinking, memory, concentration, language, mood, etc.,
which problems are the **most bothersome** to you right now?

When did you **first start to notice** that you had these symptoms?

Do you think that these symptoms have gotten **worse**, **better**, or **stayed the same**?

If they have gotten worse over time, has the process been **gradual** or **sudden**?

Are your symptoms **interfering with your day-to-day functioning**? If so, please give examples (*at work/school, at home, in relationships, in your ability to care for yourself, driving, etc.*)

What did you **used to be able to do** that you can no longer do because of your current symptoms?

What types of strategies do you currently use to compensate for your cognitive difficulties? (*for example: calendar, Palm Pilot/PDA, sticky notes, lists, reminders from family members/friends, pillbox, etc.*)

Medical History:

Please check if you have a history of any of the following

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prolonged infection | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> HIV | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Cancer (if yes, what kind? _____) | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Infectious disease (if yes, what kind? _____) | <input type="checkbox"/> Head injury (with loss of consciousness? Yes/No) | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Autoimmune disease (if yes, what kind? _____) | <input type="checkbox"/> Stroke | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Brain tumor | <input type="checkbox"/> Major Depression |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizure | <input type="checkbox"/> Electroconvulsive Therapy |
| <input type="checkbox"/> Stomach disease | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Psychiatric Hospitalization |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tourette's Syndrome/Tics | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Psychotic Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Alcohol Abuse |
| | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Drug Abuse |
| | <input type="checkbox"/> Restless leg syndrome | |

Are you currently in treatment for any of the above conditions? (Y/N) If yes, with whom? _____

Have you ever been hospitalized? (Y/N)

Have you ever had a Head CT scan Brain MRI scan EEG Lumbar puncture SPECT scan PET scan

Who is your primary care physician? _____

(For women only) Are you post-menopausal? (Y/N) Are you currently going through menopause (Y/N)

Psychiatric History and Status:

Are you currently in psychiatric treatment? _____

Are you receiving psychotherapy? _____

Have you ever been treated with psychotropic medications (medications to treat mood)? _____

Other relevant notes pertaining to your psychiatric history: _____

Currently, would you describe your mood as (circle one or more):
sad, happy, angry, anxious, apathetic, neutral or other _____

Current Symptoms: Check if you currently experience any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Trouble falling asleep | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Trouble sleeping through the night | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Waking up early in the morning and unable to fall back asleep | <input type="checkbox"/> Stomach problems (upset stomach / acid reflux / poor appetite) |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Lack of interest in things that used to be pleasurable |
| <input type="checkbox"/> Periods of no breathing during sleep | <input type="checkbox"/> Crying more often than usual (or feeling like crying) |
| <input type="checkbox"/> Trouble with driving | <input type="checkbox"/> Seeing things that aren't there/that others can't see (if yes, please describe: _____) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing things that aren't there/that others can't hear (if yes, please describe: _____) |
| <input type="checkbox"/> Pain (<i>where?</i> _____ <i>how often?</i> _____) | |
| <input type="checkbox"/> Vision problems | |
| <input type="checkbox"/> Wear glasses/contacts for reading | |
| <input type="checkbox"/> Wear glasses/contacts for distance | |
| <input type="checkbox"/> Cataracts / Glaucoma / Macular degeneration | |
| <input type="checkbox"/> Other (<i>please describe</i> _____) | |
| <input type="checkbox"/> Hearing problems (wear hearing aides? Yes/No) | <input type="checkbox"/> Lethargy/Fatigue |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Feelings of guilt |
| <input type="checkbox"/> Trouble with sense of smell (<i>when did this start?</i> _____) | <input type="checkbox"/> Feelings of worthlessness |
| <input type="checkbox"/> Trouble with sense of taste (<i>when did this start?</i> _____) | <input type="checkbox"/> Thoughts of self-harm |
| <input type="checkbox"/> Tingling or numbness in body (<i>where?</i> _____) | <input type="checkbox"/> Feeling that it is hard to go on living |

Current Medications: *feel free to attach a copy of your medication list*

Medication	Dosage	For which condition?

Health Behaviors:

Do you currently drink alcohol? **Y/N** *(If yes, approximately how many drinks per day? ____ Per week? ____)*
Have you ever been treated in the past for alcohol use or dependence? *(if yes, when? _____)*
Do you currently use any illicit drugs? **Y/N** *(If yes, please list names below, with frequency)*

Do you currently use caffeine regularly? **Y/N** *(for example, in coffee, tea, chocolate). If yes, how much per day?*

Do you exercise regularly? **Yes/No** *If Yes, how often and for how long? _____*
What type of exercise? _____

Do you smoke? **Yes/No** *If Yes, how many packs per day? _____ How long have you smoked? _____*

What time do you usually get to bed at night? _____
What time do you usually wake up? _____

Do you eat a balanced diet? **Yes/No** *How many meals a day do you eat? (circle one) 1 / 2 / 3 / 3 +*
Do you tend to eat a lot of sugar during the day? **Yes/No**
Do you eat fruits and vegetables every day? **Yes/No**
Have you ever seen a nutritionist? **Yes/No**

Do you use mind/body techniques on a regular basis? **Yes/No**
(for example: deep breathing, yoga, biofeedback, meditation)

Do you receive any alternative/non-Western therapies on a regular basis? **Yes/No**
(for example: acupuncture, massage, herbal medicine, etc)

Family Medical History:

	<i>Currently living?</i>	<i>Current age (or age when deceased)</i>	<i>Any problems with memory, concentration, thinking, or behavior? (If deceased, any problems when alive?)</i>
Mother	Yes/No		
Father	Yes/No		

Brothers/Sisters: Please list all brothers and sisters

<i>Age</i>	<i>M/F</i>	<i>Currently living?</i>	<i>Any problems with memory or thinking?</i>
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	

Does/did anyone in your biological family have any of the following?

Neurological illness or Dementia

- Alzheimer's disease (*if yes, who?* _____)
- Parkinson's disease (*if yes, who?* _____)
- Another type of dementia (*What type?* _____ *Who?* _____)
- Multiple Sclerosis or Lupus (*if yes, who?* _____)
- Epilepsy (*if yes, who?* _____)

Heart Disease or Stroke

- Stroke (*if yes, who?* _____)
- Aneurysm (*if yes, who?* _____)
- Heart Attack (*if yes, who?* _____)
- TIAs / "small strokes" / "mini-strokes" (*if yes, who?* _____)

Developmental Disorder / Learning Disability

- Attention Deficit Hyperactivity Disorder (ADD, ADHD) (*if yes, who?* _____)
- Reading Problems or Dyslexia (*if yes, who?* _____)
- Other Speech or Language Problem (*if yes, who?* _____)
- Mental Retardation (*if yes, who?* _____)
- Autism or Asperger's Syndrome (*if yes, who?* _____)

Mood disorder, Anxiety disorder, Substance abuse

- Depression (*if yes, who?* _____)
- Anxiety (*if yes, who?* _____)
- Tourette's Syndrome (*if yes, who?* _____)
- Bipolar Disorder or Manic Depression (*if yes, who?* _____)
- Schizophrenia (*if yes, who?* _____)
- Alcoholism (*if yes, who?* _____)
- Drug abuse (*if yes, who?* _____)
- Other psychiatric illness (*if yes, who?* _____)

Developmental, Educational and Vocational History:

Where were you born? _____

Where did you grow up? _____

Is English your first language? _____ (If no, what is your native language? _____)

Were there any complications during your mother's pregnancy with you (Y/N) or your birth (Y/N)?
(if yes, what were the complications? _____)

Are you right-handed left-handed ambidextrous (right and left handed)

** did you start out left-handed and become right-handed later on?

** If left-handed, are any other family members also left-handed?

Check if you were late in any of these areas compared to other children your age:

Crawling

Reading

Walking

Writing

Talking

Riding a bicycle

What is the highest level of education that you have achieved?

Pre-high school High School Associates Degree B.A. from 4-year college

Master's Degree Doctoral Degree Other professional degree _____

Where did you go to:

High school _____ (any problems noted?)

College/University _____ (any problems noted?)

Graduate school _____ (any problems noted?)

What were your average grades during the following stages of your education (circle):

Elementary School: A B C D F

High School: A B C D F

College/University: A B C D F

Graduate School: A B C D F

Academic Difficulties: Check if any of the following were true for you:

Held back a grade in school

Difficulty with math

Tested for special education

Difficulty with writing

Received special education services (i.e. speech therapy, help in reading, tutoring, etc...)

Difficulty with spelling

Poor grades

Difficulty reading

Received negative comments (eg, "Class clown" or "Does not work to potential")

What type of occupational work have you done in the past?

What type of occupational work are you doing currently?

Are you currently retired? Yes /No (If yes, when did you retire? _____ Why? _____)

Are you currently on disability? Yes/ No / Applying (If yes, for what reason? _____)

Have you ever received negative feedback from supervisors at work or school because of your current symptoms? _____

Current Context:

What is your current living situation? Alone With partner/spouse With roommates
 With other family With friends

Family:

Are you currently in a relationship with a partner/spouse? (Y/N)

Are you currently separated or divorced from a partner/spouse or a widow/widower? (Y/N)

Do you have children? (Y/N) *If yes, please list ages:*

Age	M/F	Living at home?	Any health or learning problems?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Access to healthcare: Do you have adequate access to healthcare at the present time? (Y/N)
(If no, please elaborate _____)

Psychosocial supports: Do you have adequate emotional support from others around you? (Y/N) Where do you look for support in your community? (*i.e. partner/spouse, family, colleagues, friends, religious organization*)

Stressors: How would you rate your current level of stress (*none/mild/moderate/severe*)? What are the most significant sources of stress in your life currently?

Legal History: If your current symptoms are a result of an injury, are you currently involved in a lawsuit? (Y/N) If yes, what is the current status of the lawsuit?

What do you do to help relieve stress? _____

What do you do for fun and/or to relax? _____

Current Examination:

Is there anything else that you want the examiner to know or that is particularly relevant to your neuropsychological evaluation?

Do you have any specific concerns about this evaluation?

THANK YOU